# EXHIBIT 16

# Expert Report of Christopher O'Boynik, M.D. (REDACTED)

SIGNATURE ORTHOPEDICS

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**General Orthopedics/ Total Joints**
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Kenneth S. "Buck" Smith, MD

**Hand & Wrist**
Nathan M. Fisher, DO
David C. Haueisen, MD

**Interventional Pain Management**
Christian P. Oliver, MD

**Pediatric Orthopedics**
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**Physical Medicine & Rehabilitation**
Ashok Kumar, MD
Thomas J. Malbrough, MD
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**Trauma/Total Joints**
Brian A. Fissel, MD

September 16, 2020

**Record Review**

**RE: Mohammad Wishah**
**DOB:** [redacted]

To Whom It May Concern:

| Case | Name | Service Date | Svc Procedure Desc |
|---|---|---|---|
| | | | |
| Schramke | vs. Community Health Systems Inc. | 01/07/2016 | Medical Testimony, Deposition |
| Hooten | vs. Empire Comfort System | 12/08/2016 | Medical Testimony, Deposition |
| Litchenfeld | vs. Francis Buchholz | 07/13/2017 | Medical Testimony, Deposition |
| Bath | vs. Schnuck Markets Inc. | 07/13/2017 | Medical Testimony, Deposition |
| Atkinson | vs. City Museum L.L.C. | 12/12/2017 | Medical Testimony, Deposition |
| Atkinson | vs. City Museum L.L.C. | 02/06/2018 | Trial |
| Baldesi | vs. SAK Construction LLC | 02/08/2018 | Medical Testimony, Deposition |
| Boland | vs. State Farm Mutual Auto Ins. | 02/15/2018 | Trial |
| Gorden | vs. Union Pacific Railroad | 03/29/2018 | Medical Testimony, Deposition |
| Cliffe | vs. Walgreen CO. ET AL | 10/11/2018 | Medical Testimony, Video Deposition |
| Ware | vs. General Electric | 10/25/2018 | Medical Testimony, Video Deposition |
| Juenger | vs. Juenger | 05/09/2019 | Medical Testimony, Deposition |
| Meuth | vs. Ellen M. Key | 12/05/2019 | Medical Testimony, Deposition |
| Hultquist | vs. Icon Mechanical | 01/16/2020 | Medical Testimony, Deposition |
| Givens | vs. Amsted Rail Industries | 03/05/2020 | Medical Testimony, Deposition |
| McCulloch | vs. GEICO | 07/02/2020 | Medical Testimony, Video Deposition |
| Parsons | vs. Schnuck Markets Inc. | 08/27/2020 | Medical Testimony, Deposition |
| Bryant | vs. Waterloo Community School | 09/03/2020 | Medical Testimony, Deposition |

**Publications**

O'Boynick CP, Darden BV, Casamitjana J. 2017. Cervical Spinal Disorders Associated with Skeletal Dysplasias and Metabolic Diseases. In: Rothman-Simeone: The Spine. 7th Edition. ISBN:9780323393973
O'Boynick CP, Darden BV. Cervical Disc Arthroplasty – A Clinical Review. Arthroplasty A Comprehensive Review. InTech 2016. http://dx.doi.org/10.5772/59210
Timing of surgery in thoracolumbar trauma: is early intervention safe? O'Boynick CP, Kurd MF, Darden BV, Vaccaro AR, Fehlings MG. Neurosurg Focus 37(1):E7 2014. doi: 10.3171/2014.5.focus1473
Locked versus Standard Unlocked Plating of the Symphysis Pubis in a Type-C Pelvic Injury. Moed BR, O'Boynick CP, Bledsoe JG Bledsoe. Injury. 2013 Nov 22. pii: S0020-1383(13)00551-2. doi: 10.1016/j.injury.2013.11.017. [Epub ahead of print]

**Imaging Report Review**

11/05/2007: MRI scan of the lumbar spine from Signature Health Services MRI.
Impression: Degenerative disc disease primarily at L4-5 with a left foraminal disc extrusion producing mass effect on the left L5 nerve root. Specifically at L4-5 there is diffuse disc desiccation with loss of height, moderate diffuse disc bulge with a large left paracentral and foraminal disc extrusion with caudal extension with mass effect on the left L5 nerve root. L1-2, L2-3, and L3-4 discs are within normal limits. L5-S1 shows a mild loss of height with a mild central disc herniation.

01/11/2008: MRI scan of the lumbar spine completed at Signature Health Services MRI. Comparison made to previous MRI dated 11/05/2007 indicating postsurgical changes at L4-5 with left hemilaminotomy defect. The left paracentral and foraminal disc extrusion has been removed and replaced with enhancing granulation tissue. There is no recurrent disc herniation. Disc granulation tissue surrounds the left L5 nerve root with a residual mild to moderate diffuse disc bulge adjacent to scar tissue. The remainder of the lumbar spine is unchanged.

05/13/2010: MRI scan of the lumbar spine with and without contrast from St. John's Mercy Medical Center.
In this study they identify a previous L4-5 partial facetectomy and left hemi-laminectomy. There is single level disease at the operative level. The remaining disc spaces are maintained with normal signal and stature. No significant degenerative spondylosis, herniation, or degenerative marrow changes. At L3-4, there is mild disc bulging and mild ligamentous hypertrophy. At the operative level, L4-5, there is recurrent non-enhancing inferiorly extending or extruded fragment in the left anterior epidural space causing mass effect on the left side of the thecal sac and distortion of the nerve takeoff. L5-S1 shows minimal central disc protrusion and mild right-sided facet disease.

05/11/2011: MRI scan of the lumbar spine with and without IV contrast from Old Tesson Medical Office Building. Comparison is made to previous MRI dated 05/13/2010. There is progression of endplate degenerative signal change on the right side enhancing after contrast. There are postoperative changes involving the left laminectomy and facetectomy at L4-5. No significant disc bulging at L1-2, L2-3. There is minimal disc bulging at L3-4. L4-5 again demonstrates herniated disc material centrally and in the left foraminal zone with slight inferior migration of the left lateral recess with extension into the left lateral recess, slightly larger than the prior exam and more paracentrally located. L5-S1 shows a tiny central disc protrusion with bilateral facet arthropathy.
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10/19/2017: MRI scan of the lumbar spine without contrast from Professional Imaging. Clinical data includes low back pain, right leg pain and numbness. Findings include L1-2 and L2-3 to show normal disc size without significant disc profile abnormality, canal stenosis or neural foraminal stenosis. At L3-4, there is circumferential disc bulge to 2.5 mm, no focal

protrusion. This combines with ligamentum hypertrophy and results in borderline central canal stenosis and mild bilateral foraminal stenosis. L4-5 shows a previous micro-decompression changes and left-sided laminotomy defect. Disc bulge measures



7 to 8 mm in both foramina, which along with foraminal height loss causes severe right greater than left foraminal stenosis with mild central stenosis. L5-S1 shows a hyper-intense zone with an annular tear of the apex of a 3.5 mm protrusion. No central or foraminal stenosis.

08/17/2018: MRI scan of the lumbar spine without contrast completed at Barnes Jewish Hospital for low back pain. L1-2 shows a normal disc configuration without foraminal or spinal stenosis. L2-3 shows a small disc bulge with moderate facet arthritis and moderate left and mild right neural foraminal stenosis with mild spinal stenosis. L3-4 shows a small disc bulge combined with mild facet arthropathy and moderate left neural foraminal stenosis and mild spinal stenosis. L4-5 shows a moderate sized disc bulge with mild facet arthropathy and mild right and moderate left neural foraminal stenosis with mild canal stenosis. L5-S1 shows a moderate sized disc bulge without facet arthropathy and mild bilateral neural foraminal stenosis.

10/22/2019: MRI scan of the lumbar spine completed at Barnes Jewish Hospital. Comparison is made to MRI from 08/17/2018. This identifies mild retrolisthesis of L3-4 with Modic changes at L4-5. L1-2 shows a normal disc configuration without foraminal or central stenosis. L2-3 identifies mild disc bulge with moderate facet arthritis and mild left foraminal stenosis, no spinal stenosis. L3-4 shows a mild disc bulge with mild bilateral facet arthritis and moderate left foraminal stenosis without spinal stenosis. L4-5 demonstrates diffuse disc bulge with moderate facet arthritis and moderate bilateral foraminal stenosis with mild spinal canal stenosis. L5-S1 shows a disc bulge with central protrusion and mild bilateral facet arthritis with mild foraminal stenosis bilaterally. Mild spinal canal stenosis is also seen in the right lateral recess along with the spinal canal. Impression on this date is stable degenerative changes of the lumbar spine most pronounced at L4 through S1.

**Record Review:**
Undated intake form completed by Mr. Wishah identifies an HPI of herniated disc, bulging discs, sciatica, lower back and leg pain. Symptoms started in 2004 and were constant after slipping on steps. Activities including walking, sitting, standing and laying down make the symptoms worse. No activities improve or lessen the symptoms. There is tingling and numbness in the legs with restless legs.

09/24/2007: Office note completed by Dr. Yoon indicates a 52 year-old male with low back pain for about one year, worse over the last three months with radiation into the left leg, EHL weakness and positive straight leg raise. MRI shows L4-5 disc herniation consistent with the left-sided radiculopathy. Recommend L4-5 discectomy on the left.

11/07/2007: Note completed by Dr. Yoon indicates the patient presents with low back pain and left leg pain with a known herniation at L4-5. New MRI completed prior to his visit shows a large L4-5 extruded fragment within the foramen along with exam showing slight weakness of the EHL and positive straight leg raise testing. Recommend surgical decompression.

11/21/2007: Operative note completed by Dr. Yoon indicating the successful completion of a left L4-5 discectomy for left leg radicular pain. There were no complications.

12/23/2008: Operative note completed by Dr. Yoon indicates an uncomplicated L4-5 re-exploration and discectomy on the left side.

01/12/2009: Note completed by Dr. Yoon. Mr. Wishah follows up three weeks after an L4-5 discectomy for recurrent disc herniation. He had a very large central extruded disc herniation at this level and had both an L5 and S1 radiculopathy with continued numbness. EHL and anterior tib weakness is definitely improving but patient still has persistent posterior thigh pain with persistent S1 weakness. He is unable to stand up on the tiptoes on the left side. We will wait four more weeks before repeating MRI.



05/20/2015: Notes from St. Louis University Hospital indicate an ED visit for unrelated complaint of chest pain, left arm pain and a history of chronic back pain. There were no diagnostic studies with respect to the lumbar spine completed on this date.

10/30/2017: Dr .Yoon completes an office visit note for Mr. Wishah. The patient presents with low back pain and bilateral leg pain and radiation alternates but more on the left than the right into the top of the foot or dorsum of the foot with burning. There is a history of multiple lumbar decompression surgeries. The current pain is more or less burning in a discrete dermatomal pattern. MRI of the lumbar spine shows collapsed disc space at L4-5 with spondylolisthesis Grade I, and lateral recess stenosis bilaterally that appears to be consistent with symptoms. His symptoms would be suggestive of an arachnoiditis with burning dysesthesias. Recommend continued pain management, but decompression/fusion is an option.

10/30/2017: Os Westry Low Back Pain Disability Questionnaire finds an ODI rating per this document of 84%.

10/30/2017: A note completed by Dr. Yoon. Mr. Wishah returns with lower back pain and bilateral leg radiation alternating but more on the left than the right. History of multiple lumbar surgeries. MRI shows collapsed disc space at L4-5 with Grade I spondylolisthesis and lateral recess stenosis, consistent with his symptoms. Symptoms suggest arachnoiditis with burning dysesthesia. Continue pain management.

07/25/2018: Office note from Dr. Ricky Mui at SSM Health. Diagnosis on this visit includes: Fall with initial encounter for acute bilateral low back pain without sciatica, assault and chest wall pain. X-ray reports of the lumbar spine from this ER visit demonstrate no evidence for acute fracture or malalignment with moderate to severe loss of disc height at L4-5 and facet arthritis with minimal anterolisthesis of L4 on L5. Sacrum views and coccyx views show no evidence of acute fracture or malalignment. Further documentation from this ED visit completed by Shannon Smith, RN indicates the patient presented to the ED via EMS after being assaulted per Country Club Police Department. The patient reports needing PD at the family's store without arrival. Went to the store next to them and seen the PD there, asked why they never showed up and words were exchanged. The patient reports to leaving and the PD went out and confronted him. When trying to walk away the police department stepped on his feet and shoved him real hard causing him to fall back and he hit his head without LOC. Back pain and slight pain in the back of the head. The patient presents at 06:46 a.m. with lower back pain described as tightness that began yesterday after getting into an altercation. He was pushed and fell backwards and they stepped on his feet. He did hit his head but denies loss of consciousness. Physical examination of the lumbar spine shows no obvious bruising to the back. Neurologically the patient is alert and oriented to person, place and time. There is no saddle anesthesia. Lower extremity strength is 5/5. Sensation is commented on but not rated as intact or absent. The patient ambulates with his cane at baseline. The summary indicates the patient was then re-evaluated for right-sided pain requesting right-sided rib x-rays, which were negative. Recommend discharge home at this time. Diagnosis: Right sided chest pain, back pain and tailbone pain status post assault.

03/20/2019: ED notes completed by Lawrence Brown, MD indicates Mr. Wishah presented to the ED after being pistol whipped in the back of the head multiple times, suffering multiple lacerations. Physical examination demonstrates no specific examination of the lumbar spine but does demonstrate 5/5 strength in the bilateral upper and lower extremities with subjectively decreased sensation to light touch in the left lower extremity, which is at baseline at previous.

04/17/2019: Report completed by Dr. Allen Morris from MedEx. The patient presents on this date with back and left leg pain. [redacted] Per this document, the claimant has had three back surgeries, most recently by Dr. Yoon as well as a procedure in 2010 at The Laser Spine Institute. Reports indicate a Grade I spondylolisthesis at L4-5 with lateral recess stenosis and arachnoiditis. The patient is following with Dr. Hayden for pain management. MRI report done on 08/17/2018 is compared with the one done on 08/18/2017. The imaging study most recently was ordered by Dr. Hayden as the claimant was involved in an altercation where he was thrown to the floor by police. The MRI report was then reviewed on this date. Per this document, the claimant's complaints are unchanged from 03/28/2018 with constant back pain and left leg



pain. He requires a cane at all times. The claimant can sit, stand, and walk but only for five minutes each and does not do any lifting. The cane, again, is required full time. Previously on 03/28/2018, the claimant was found to have permanent disability and should be followed by pain management. On examination, the patient limps favoring the left leg, using a cane. Forward flexion was maintained to 20 degrees while standing with further lumbar flexion to 40 degrees and there was 0 extension with right and left lateral bending to 15 degrees. There are three scars on the lumbar spine including a midline and two paramedian scars. The patient requires his cane for mobilization in the office. Reflexes are absent at both knees, trace on the right ankle, absent on the left ankle. Straight leg raise is 90 degrees on the right with no pain, 70 degrees on the left with low back pain while sitting. Supine straight leg raise is 60 degrees bilaterally, right and left with low back pain bilaterally. Anterior tib and extensor hallucis longus weakness is present on the left at 2/5 strength. Assessment on 04/17/2019: The patient is status post multiple back surgeries with degenerative disc disease and spondylolisthesis at L4-5. Most recent MRI as of 08/17/2018 does not describe any specific degenerative disc disease or spondylolisthesis. There is also a history of a spinal arachnoiditis.

11/20/2019: Os Westry Low Back Pain Disability Questionnaire was administered and scored at 82%.

11/25/2019: Office visit by Dr. Peter Yoon. In this note, Dr. Yoon documents Mr. Wishah has had a history of lower back pain for many years with a history of lumbar discectomy followed by re-exploration and continues to have pain into the left leg. He had a third surgery in Tampa, Florida. The pain continued. He has been to the office serval times with persistent pain, utilizing a cane. The pain had been relatively stable, however, he was involved in an assault earlier in the year, where he was pushed from the front and fell backwards onto the sidewalk. Pain has been worsening since that time. Examination shows symmetrical reflexes with negative straight leg raise testing bilaterally. The patient ambulates with a cane. MRI of the lumbar spine shows generally progressive degenerative change and epidural fibrosis with L4-5 foraminal stenosis, left is worse than right with Grade I spondylolisthesis. Dr. Yoon identifies degenerative changes that have progressed in the setting of chronic pain and recommended consideration for re-exploration with lumbar fusion and insertion of interbody device if possible.

Another undated document includes an HPI with the main problem of being severe back pain, started in 2004 after slipping on some steps. Pain is severe, aching, sharp, burning throughout and shooting with severe inflammation, worsened with activities. Improved with lying down and having an ice pack under the back and elevating the legs. Under evaluation of present illness is written that the back is getting worse since 2017 to 2018 to 2019 but between years my back has been through serious impacts, twice last year and this year. Treating with pain management with Dr. Hayden.

11/25/2019: Neurosurgical history and physical completed by Dr. Yoon identifies a 54 year old male with severe 7 to 8/10 pain in the lower back radiating into the left leg, on left worse than right L4-L5 and most of the big toe on the left with right radiation that is nonspecific with paresthesias. This is brought on by prolonged periods of standing and sitting. The patient relays that he was involved in an assault in which he was pushed and fell backwards last year in July and the pain has worsened since then especially with left leg radiation.

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**Video Review**
Video dated 07/25/2018 at roughly 03:06 a.m. per the time stamp on the video itself, a roughly 18 second video demonstrating a gentleman wearing gray camo pants and a gray camo shirt standing in the doorway of what appears to be a convenience store. At roughly the 1 to 2 second mark of the video, the patient is pushed to the ground by an officer, with the gentleman landing on his low back on the concrete. He then stands up under his own power and is escorted to his vehicle where a discussion that is inaudible ensues.

**Imaging Review:**
MRI lumbar spine dated October 2017 is reviewed. T2 weighted axial cuts at L1-2 and L2-3 demonstrate no significant disc herniations, no significant mass effect on the nerve roots or the thecal sac. At L3-4 there may be some mild facet hypertrophy but no significant central or lateral recess stenosis. At L4-5, there is a previous left-sided laminotomy defect with perhaps some residual disc material or scar within the spinal canal, specifically within the lateral recess on the left side. This may create some mass effect on the traversing L5 nerve root. There is no contrast and thus I cannot determine if there is any enhancing scar tissue. The L5-S1 level shows a small centralized disc bulge without significant mass effect on the traversing S1 nerve roots. Reviewing T2 weight sagittal cuts, there are Modic endplate changes at L4-5 with loss of disc height and a subtle Grade I spondylolisthesis. In reviewing these axial and ensuing sagittal cuts, there is moderate to moderately severe left-sided foraminal stenosis secondary to degenerative disc bulge out into the foraminal space and loss of disc height in concert with facet hypertrophy.

MRI of the lumbar spine dated 08/17/2018 from Barnes Jewish Hospital is reviewed. T2 weighted sagittal cuts and axial cuts show the L1-2 and L2-3 disc spaces show no significant change. L3-4 shows a slightly broad-based disc bulge. This does not appear to be demonstrating significant pressure on the traversing or exiting nerve roots. At L4-5, there is continued spondylitic change with loss of disc height. There is a previous laminotomy defect on the left at L4-5 with some residual tissue within the lateral recess on the left side consistent potentially with scar. This is not a contrast study, so I cannot determine if there is residual disc material or if this enhancing scar tissue but there remains lateral recess stenosis on the left side. There is moderate to moderately severe foraminal stenosis secondary to loss of disc height, disc herniation as well as facet arthropathy on the right side. Again, there is moderate foraminal stenosis maybe moderately severe secondary to loss of disc height and a degenerative disc bulge. At L5-S1, there is a centralized disc bulge that appears to be larger at this level than on the previous study dated 2017.

MRI of the lumbar spine dated 10/22/2019 from Barnes Jewish Hospital is reviewed. In reviewing the T2 weighted axial and sagittal cuts, L1-2 and L2-3 do not demonstrate significant change in terms of their overall appearance. There is no disc herniations or significant mass effect on the traversing or exiting nerve roots at these two levels. At L3-4, there may be slight progression in the disc bulge at L3-4 with some moderate lateral recess stenosis at L3-4. The foraminal spaces

appear mildly narrowed. There may be a subtle left-sided disc bulge at L3-4 into the lateral recess which is changed from previous study.
L4-5 again we see advanced degenerative change. I do not see a significant difference in the overall appearance of the disc space. There is Modic endplate changes as well as this degenerative disc herniation and the previous laminotomy defect. All this works in conjunction to create lateral recess stenosis. Again, this is a non-contrast study so I cannot determine if there is any enhancing scar versus disc material at this level but there is lateral recess stenosis and advanced degenerative change with foraminal narrowing, more severe on the left than the right but present bilaterally. L5-S1 again demonstrates a centralized disc bulge with perhaps some slight mass effect on the traversing S1 nerve roots but there is no significant lateral recess stenosis or foraminal stenosis at this level.

**Assessment**
Mr. Mohammad Wishah is a gentleman with a very complex medical and surgical history as it relates to the lumbar spine. In roughly 2007 he underwent an elective microdiscectomy for left leg radiculopathy. That was complicated by recurrent disc



herniation requiring a subsequent decompressive surgery at L4-5, yet again on the left side. That was undertaken in roughly 2008.

At some time in 2010, per the records provided, the patient then underwent a third decompressive surgery at The Laser Spine Institute; however, those records are not available. Since 2007 the patient has had waxing and waning courses of lumbar spine pain and left leg radiculopathy with pain, weakness and numbness and tingling.

On or about 7/25/2018, per ER documentation as well as a video provided to me, Mr. Wishah was pushed to the ground by a police officer landing on his lumbar spine. Per the records provided, specifically those documented by Dr. Yoon, the patient reports increased left lower extremity pain since that altercation.

MRIs have been obtained multiple times and I have reports dating back to 2007 of those MRI results, however, I have hard copy images of these studies dated 2017, 2018 and 2019. Those studies demonstrate what I would consider to be the aging process of the lumbar spine particularly as a postoperative spine. I see some mild degenerative changes across those MRIs of 2017, 2018 and 2019 without significant changes in the sizes of the disc herniation to indicate a traumatic event in the overall disc appearance at L3-4, L4-5 or L5-S1. There may be subtle changes in the size of the L5-S1 disc bulge centrally but that can be secondary to technique or orientation of the gantry or other tech-dependent factors involving MRI. Specifically at the index level of L4-5, I think we see continued degeneration across these MRIs without a new or large or recurring disc herniation.

However, per the documentation provided, again from Dr. Yoon, Mr. Wishah continues to have significant left lower extremity radiculopathy with pain and discomfort along with numbness and tingling and per his report, this has increased since the altercation on 07/25/2018. I think it is possible and more likely than not results from being pushed to the ground and striking the lumbar spine on the concrete thus aggravating an underlying condition to the point that further medical or surgical management may need to be undertaken. I do not think there is any question this patient has had an ongoing battle with left lower extremity pain and low back pain secondary to this L4-5 level. In an already degenerative surgically treated lumbar spine, it is possible that a trauma such as the one described and identified on video could result in an aggravation in the underlying condition. This aggravation can be temporary or it can be permanent and only time will tell whether or not this is a permanent aggravation of an underlying condition but as of the documentation provided to me, I see no significant evidence that this is improving for Mr. Wishah.

It remains my opinion as of the completion of this medical record review that it is possible and more likely than not a result of the injury as described and identified in the ED records from 07/25/2018 as well as viewed on video could aggravate an underlying condition and cause further pain potentially necessitating further intervention in the form of medical or surgical management for this patient's continued complaints.

While again to reiterate that I do not see any obvious structural differences between the MRI in 2018 and that of 2019, we can see aggravation of patient's symptoms in the setting of an underlying condition without significant change on an MRI. This can come about in traumatic events such as auto accidents, falls, assaults, and other things of that nature that do cause trauma to an already degenerative and abnormal lumbar spine. It is my suspicion that this is what has happened in this case.

Sincerely,

Christopher P. O'Boynick, MD
CPO/caw